TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-0793-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on DRG 505, allowed amount is $10,160.72 multiplied at 143%, the account reimbursement should be $14,529.83. Payment received was only $14,023.32, thus according to these calculations; there is a pending payment in the amount of $506.51."

Amount in Dispute: $506.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For dates of service 12/1/15 – 12/4/15, the Carrier issued initial and reconsideration EOBs allowing $14,023.32. Those EOBs are attached. By letters of August 29, 2016 and November 30, 2016 [attached], the Carrier informed the Requestor that the original payment was based on outdated CMS data. Using the CMS Inpatient Pricer and the correct CMS data, the total amount due was $13,978.93 ($9,775.04 x 143%)."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1 – 4, 2015	Inpatient Hospital Services	$506.51	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers Compensation jurisdictional fee schedule adjustment
   - W3 – Request for additional allowance was denied

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeding additional reimbursement in the amount of $506.51 for inpatient hospital services rendered from December 1 – 4, 2015. The carrier reduced the billed charges with adjustment code P12 – "Workers compensation jurisdictional fee schedule adjustment."

   Inpatient acute care hospital reimbursement is subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which states

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register.

   Per §134.404(f)(1),

   > The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables.

   Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A and is found below.

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%.

   Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov.

   Review of the submitted medical claim finds that the DRG code assigned to the services in dispute is 505. The services were provided at Doctors Hospital at Renaissance. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $9,775.04.

   Step 1: Calculate the Medicare facility specific reimbursement amount plus any applicable outlier payment

   The division establishes the total Medicare facility specific amount in this case using the *Medicare Inpatient PPS PC Pricer* as a tool. The *Medicare Inpatient PPS Pricer* efficiently identifies facility specific payment factors and adjustment. The pricer is found at www.cms.gov.

   The following illustrates the division's calculation of the total Medicare facility specific amount:

TOT DRG AMT:	Add back VBP CR *(not applicable due to conflict with Texas Labor Code)*	Add Cost Outlier *(applicable)*	Total Medicare Facility Specific Amount
$9775.04	+ $19.29	+ $0.00	$9,794.33

   Note that a claim reduction identified as "VBP CR" on the *Medicare Inpatient PPS Pricer* was added back into the total DRG amount for this admission. "VBP CR" stands for Value-Based Purchasing (VBP) claim reduction (CR) which in Medicare is used to fund the Medicare VPB program. Medicare's VBP program was

implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. Consequently, the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence:

> 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

For this reason, the VBP CR amount does not apply. The VBP claim reduction amount was therefore added back in because it does not apply to inpatient hospital services provided in the Texas Workers' Compensation system.

Step 2: Multiply the total Medicare facility specific amount by 143%

The reimbursement calculation is therefore:

Total Medicare Facility Specific Amount	28 TAC §134.404 (f)	Total DWC Reimbursement
$9,794.33	$9,794.33 x 143%	$14,005.89

The total allowable reimbursement for the services in dispute is $14,005.89. This amount is recommended.

3. The total recommended payment for the services in dispute is $14,005.89. The insurance carrier has paid $14,023.32. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 22, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.